



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

Ruben St. Laurent, DC

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-14-3571-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

August 4, 2014

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We requested a reconsideration from the insurance, Texas Mutual, for a claim ... for date of service 04/04/2014 in the amount of \$1615.00, for a Designated Doctor Exam. We received partial payment of \$1465.00. We submitted a reconsideration request on 07/01/2014, for the remaining balance of \$150.00. The denial reason(s) per EOB are: Workers Compensation fee schedule adjustment. Designated Doctor Exams are billed according to DWC rule 134.204 and accordance with labor code 408.004, 408.0041, and 408.151."

**Amount in Dispute:** \$150.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The requestor argues it is due an additional \$150.00 for impairment rating involving the right 5<sup>th</sup> toe in addition rating of the right ankle. Texas Mutual paid \$300.00 for a rating to the lower extremity. With respect to the fee schedule that is the correct payment amount."

**Response Submitted by:** Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 4, 2014	Impairment Rating for multiple body parts	\$150.00	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 (j)(4) explains how Impairment Ratings are to be billed and reimbursed.
3. 28 Texas Administrative Code §130.1 (c)(3) defines the required information for an impairment evaluation.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - CAC-W1 – Workers Compensation State Fee Schedule Adjustment.
  - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services. For information call 1-800-937-6824.

### Issues

1. Did the requestor bill appropriately for multiple body parts?
2. Is the requestor entitled to additional reimbursement?

### Findings

1. 28 Texas Administrative Code §134.204 (j)(4)(C) states, “For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and, **(III) lower extremities (including feet)**. (ii) The MAR for musculoskeletal body areas shall be as follows. (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area; and (-b-) \$150 for each additional musculoskeletal body area” [emphasis added]. Impairment rating was evaluated only for the right 5<sup>th</sup> toe and right ankle. The right 5<sup>th</sup> toe and right ankle are both part of the lower extremity. Therefore, the provider may only bill for one musculoskeletal body area.
2. 28 Texas Administrative Code §130.1 (c)(3) states: “...The doctor assigning the impairment rating shall: (A) identify objective clinical or laboratory findings of permanent impairment for the current compensable injury; (B) document specific laboratory or clinical findings of an impairment; (C) analyze specific clinical and laboratory findings of an impairment; (D) compare the results of the analysis with the impairment criteria and provide the following: (i) **A description and explanation of specific clinical findings related to each impairment**, including zero percent (0%) impairment ratings; and (ii) A description of how the findings relate to and compare with the criteria described in the applicable chapter of the AMA Guides. The doctor’s inability to obtain required measurements must be explained.” [emphasis added] Since no IR evaluation was performed for body areas other than the lower extremity, no further reimbursement is due.

### Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Signature	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <b>Laurie Garnes</b> Medical Fee Dispute Resolution Officer	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <b>December 3, 2014</b> Date
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### **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee***

***Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**